PROCEDURES FOR CONTINUITY OF CARE
between
COMMUNITY SERVICES BOARDS
and
STATE PSYCHIATRIC FACILITIES

(Revised Client Service Management Guidelines)

February 3, 1997

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INTRODUCTION

Purpose of the *Continuity of Care Procedures*

Consistent with the State Mental Health, Mental Retardation and Substance Abuse Services Board Policy on Client Management, the *Procedures for Continuity of Care* outline the basic operational roles, responsibilities, and expectations of community services boards (CSBs) and state psychiatric facilities in managing the care of individuals they serve. These procedures reflect important goals of our system of care: meeting the needs of individuals and families; establishing and supporting effective collaboration between community services boards and state facilities; involving individuals and families in treatment planning and service delivery; and working assertively with courts, sheriffs, and other agencies on behalf of individuals who need services. These procedures focus on a discrete subset of interactions between community-based service providers and state psychiatric facilities which share responsibilities for activities related to the pre-admission, hospital liaison, and discharge and follow-up processes.

These procedures conform to the Code of Virginia and, to the extent possible, are consistent with standards contained in the Department's Rules and Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, Commission on Accreditation of Rehabilitation Facilities (CARF) standards, and Healthcare Finance Administration (HCFA) standards. The procedures are predicated upon and guided by the Department's mission, values, and principles of service development and delivery as described in Virginia's Mental Health Plan. These values and principles are listed in Appendix G of this document.

Lastly, it is recognized that managed care and other influences have caused and will continue to cause substantial changes in Virginia's mental health, mental retardation and substance abuse services system. The *Procedures for Continuity of Care* are offered to update the framework initially articulated in the 1988 Client Service Management Guidelines which offered a structure for the working relationship between community services boards and state psychiatric facilities relative to the management of client care. This document offers a revised framework reflecting concepts related to quality, continuity of care, and accountability, as well as Departmental policy and recent statutory changes. The *Procedures for Continuity of Care* will be re-evaluated in light of system change as it occurs.

Replacement of the Client Service Management Guidelines

These procedures replace the Client Services Management Guidelines, which have been in effect since July 1, 1988. CSBs and state psychiatric facilities should jointly develop mechanisms to operationalize the new *Procedures for Continuity of Care.*

Organization of the Continuity of Care Procedures

This document contains three types of information:

- ✓ Procedures that are related to hospital admissions, treatment planning, and discharge planning;
- ✓ Practitioner Guidance statements, which are contained in the procedures, that describe good practices in carrying out the procedures and recommend resource and reference materials;
- ✓ Appendix documents and Virginia Code Sections referenced in the text.

1 EMERGENCY AND CRISIS RESPONSE SERVICES

Introduction

Emergency and crisis response services are essential components of a community support system for adults with mental illness, mental retardation, or substance abuse and for children with serious emotional disturbance, mental retardation, or substance abuse. These services are short-term interventions aimed at resolving crises and supporting individuals in the least restrictive and most normalizing ways. These services must be in place in order to effectively manage the use of limited and costly inpatient hospital services.

Procedures

1.1 All community services boards shall provide emergency and crisis response services that are available 24 hours per day, seven days per week.

1.2 Emergency and crisis response services shall include, at a minimum: telephone interventions; face-to-face assessments and evaluations (including pre-admission screening); psychiatric consultation and other clinical consultation about medical conditions, substance abuse and special populations which include children, adolescents, older adults, people with mental retardation, and individuals involved in the forensic system.

1.3 When face-to-face crisis interventions are deemed appropriate, community services boards shall make every effort to insure such interventions are available and accessible throughout their respective catchment areas within one hour of initial contact for urban community services boards and within two hours of initial contact for rural community services boards.

Practitioner Guidance: It is recognized that there will be circumstances in which the above-noted response intervals will be increased due to factors involving distance and travel time, staffing levels, clinical acuity, and the amount of clinical activity in progress. These time frames are intended to serve as targets; failure to meet these targets should be the exception.

1.4 Crisis response services shall be available to any individual who is physically present within the community services board's catchment area regardless of where the individual legally resides.

1.5 When emergency and crisis response services are provided in collaboration with other agencies or organizations or through other arrangements with outside providers, these arrangements shall be described in formal written agreements, that is a contract, a letter of agreement, or joint procedures. When such other arrangements are adopted, the community services board shall retain responsibility for monitoring and ensuring the

providers' compliance with these procedures and all other Departmental policies and procedures relevant to facility admissions.

1.6 Emergency and crisis response services shall be provided by clinicians who have the knowledge, skills, abilities, and experience that qualify them to provide these services. This shall include knowledge of and experience with emergency access to community and hospital services and resources; mental status examinations and pre-admission screening of adults, minors, and individuals with other special needs and conditions (see 1.2, above); clinical approaches and treatment methods; and relevant statutes and procedures.

Practitioner Guidance: *Community services boards should develop printed lists of emergency services and other programs, resources, and supports for individuals who could benefit from these services. Examples include mobile outreach services, warmlines, consumer drop-in centers, public and private human services agencies, and support groups. These lists should be given to emergency services clinicians for their use and for distribution to others.*

.7 Prior to the disposition of an emergency situation, emergency and crisis response clinicians shall attempt to identify and contact any other current service providers and appropriate significant persons (such as a guardian or a minor's parent) to obtain additional information and their recommendations for intervention.

1.8 When the individual in need of crisis services has a dual diagnosis of mental retardation and mental illness, community services board mental retardation and mental health staff shall follow the procedures delineated in the appropriate Regional Crisis Stabilization Protocol. (See Appendix K).

1.9 In order to respond most effectively to crises, emergency and crisis response clinicians shall have timely access to relevant clinical, treatment, and demographic information about the individual maintained by the community services board.

The emergency response clinician shall not refer an individual who has received face-to-face emergency services to a state psychiatric facility without direct communication with a representative of the receiving facility. No individual shall be transported to a facility prior to confirmation and acceptance of the referral by the receiving facility. Such referrals shall include provisions for the individual's transportation.

If the individual receiving face-to-face emergency services is a consumer of a different community services board, or is a resident of a different CSB catchment area, then, whenever feasible and appropriate, clinicians from both CSBs shall discuss and concur with the proposed emergency intervention and agree upon responsibility for any follow-up of the individual.

Practitioner Guidance: *A community services board may release and exchange any such information that is needed to formulate and effect emergency treatment when the individual who is the subject of face-to-face emergency services or his parent, guardian,*

or committee refuses to authorize the release of information that may be necessary to formulate and implement a proposed emergency intervention. It is the intent of this procedure that any information exchanged about an individual be used only to facilitate a coordinated and well-formulated emergency response and intervention and that such information shall be protected from disclosure for any other purpose to any other person or organization.

2. PREADMISSION SCREENING AND ADMISSION TO INPATIENT PSYCHIATRIC HOSPITALS

Introduction

Preadmission screening ensures the ability of the community services boards to manage and coordinate admissions to:

- State psychiatric facilities;
- Private psychiatric hospitals under contract with the Department;
  Private psychiatric hospitals utilized by community services boards; and
  Private psychiatric hospitals for Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Medicaid recipients under age 21.

Preadmission screening by community services boards also assures that limited hospital resources are used appropriately and begins the process of community services board involvement in hospital treatment for the individual. The preadmission screening process serves to verify an individual's need for inpatient psychiatric hospital services and to divert individuals, for whom less restrictive alternatives are appropriate, from admission to an inpatient facility. Preadmission screening provides a uniform method of entry into all state psychiatric facilities and it is required by the Code of Virginia (§§ 37.1-65, 37.1-67.3, 37.1-197.1).

Procedures

2.1 All individuals being considered for voluntary admission to state psychiatric hospitals and contracted private hospitals shall be prescreened by community services boards prior to admission. All individuals who are admitted to any public or private hospital on an involuntary basis must also be prescreened. The prescreening shall be a face-to-face evaluation that is conducted by the community services board serving the catchment area in which the individual is physically located. The prescreening can take place at the community services board or any other agreed upon and appropriate location.

Practitioner Guidance: *CSB preadmission screening for inpatient psychiatric services under EPSDT is required for Medicaid recipients under age 21. Both state facility and private psychiatric hospital EPSDT admissions must be prescreened by the CSB.*

Practitioner Guidance: *A prescreening evaluation can be initiated by an Emergency Custody Order, a request for a Temporary Detention Order, a Petition for Involuntary Commitment, or by a request from a citizen, minor (older than 14 years), parent, police officer, or agency to evaluate an individual for psychiatric hospital admission.*

Practitioner Guidance: *Some forensic patients who are admitted to state psychiatric facilities pursuant to certain sections of the Virginia Code do not require preadmission screening by the community services board. Types of forensic legal status,*

corresponding code sections, and requirements for prescreening are reflected in the table entitled "Legal Status of Individuals Requiring Forensic Treatment." (See Appendix E).

***Practitioner Guidance**: Preadmission screening for persons who are mentally retarded and mentally ill should involve staff from both the mental retardation and the mental health programs of the community services board in accordance with the established Regional Crisis Stabilization Protocol.*

***Practitioner Guidance**: The clinician should inform the individual and his or her family that there is a cost for the prescreening evaluation and that the community services board will work with the individual and his or her family to determine their financial obligation.*

***Practitioner Guidance**: The clinician should inform the individual and his or her family that there is a cost for inpatient hospital treatment and that they will be billed by the hospital for inpatient treatment. The hospital will work with the individual and his or her family to determine their financial obligation as appropriate.*

Transfers from private psychiatric hospitals to state psychiatric hospitals shall be made in accordance with Departmental Instruction 6. (See Appendix C).

***Practitioner Guidance**: In accordance with private hospital transfer procedures outlined in Departmental Instruction No. 6, a preadmission screening by the community services board may not be required before the actual transfer to a state psychiatric facility. When a preadmission screening has been conducted by the community services board before the admission to the private facility from which transfer to a state facility is sought, the community services board in consultation with staff of the receiving state hospital should determine whether a second prescreening evaluation is warranted and may dispense with this second evaluation if it is deemed unnecessary.*

The community services board serving the catchment area in which the individual is physically located is responsible for performing the prescreening evaluation. When an individual is a resident of another community services board catchment area, the prescreening CSB may contact the "home" or "Case Management CSB" to solicit consultation from that CSB and to confirm the "Case Management CSB" designation. The "Case Management CSB" is defined as the CSB that serves the area in which the individual being admitted resides. The "Case Management CSB" is responsible for case management, CSB liaison during hospitalization, and the implementation of the discharge plan. (See Appendix F).

Consultation from other community services board staff shall be available to emergency services and crisis response staff to assist them with the prescreening process and the determination of need for hospitalization. Consultation shall be available in the following specialty areas: forensics, child and family services, substance abuse, mental retardation, geriatric services, and general medical clearance.

Practitioner Guidance: *The community services board should also make arrangements for translation services to be available for individuals who do not speak English or who are hearing impaired.*

2.5 When the prescreening involves a minor under the age of 14, community services board staff shall contact the minor's parents or guardian to obtain parental consent for the prescreening and admission. A minor 14 years or older is deemed an adult for purposes of consent for voluntary treatment. The minor's parents or guardian can petition for involuntary admission over the minor's objection and minor may also be involuntarily committed over their parent's or guardian's objection.

When the clinician's evaluation indicates that inpatient psychiatric hospitalization is required, such information shall be recorded on the DMHMRSAS Preadmission Screening Form (DMH 224 rev. 4/94).

Practitioner Guidance: *Timely and complete clinical information conveyed during the admission process helps to assure a smooth transition and the delivery of prompt, effective inpatient care and treatment. Any standardized functional assessment instruments being used by CSBs for adults and minors should be completed in full with all relevant information provided to the facility.*

The clinician shall ensure that all available information that can assist the hospital in admitting and treating the person accompanies the individual to the hospital. At a minimum, this information must include a fully completed Preadmission Screening Form (DMH 224), all court orders (e.g., detention orders, commitment orders, etc.), and other documents related to the admission.

Practitioner Guidance: *It is always helpful to hospital staff to have as much relevant information about the individual as possible upon admission so that treatment and discharge planning can be initiated promptly. Additional helpful information includes other clinical information and school and court records.*

Practitioner Guidance: *For child and adolescent admissions, it is helpful to note on the prescreening form the name, address, and telephone number of the child's parents or guardian.*

Practitioner Guidance: *When a private provider is involved with the individual, the clinician should write the name, address, and telephone number of the provider on the prescreening form or in the evaluation forwarded to the hospital.*

Practitioner Guidance: *For individuals involved in the forensic system, §19.2-174.1 of the Code of Virginia may apply. (See Appendix E).*

Practitioner Guidance: *For individuals with mental retardation and mental illness, it is important that the names, addresses, and telephone numbers of key community services*

board mental retardation and mental health program staff be included on the prescreening form.

2.8 All admissions shall be processed in accordance with the applicable statutory provisions.

Practitioner Guidance: Several types of hospital admissions can occur based upon the severity of the individual's presenting problems, the type of admission requested, the person's capacity to give informed consent, the presence of criminal charges, and the age of the individual. The different types of hospital admissions and their requirements are found in the Code of Virginia. They include:

- *Voluntary Admission of Adults, Age 18 and Older (§ 37.1-65);*
- *Voluntary Admission of a Minor, Age 0 through 17 (§ 16.1-338);*
- *Mental Examinations and Treatment of Minors (§ 16.1-275);*
- *Commitment of Mentally Ill or Mentally Retarded Children (§ 16.1-280);*
- *Voluntary Admission of an Objecting Minor Age 14 through 17 (§ 16.1-339);*
- *Involuntary Admission of an Adult (§ 37.1-67.3);*
- *Involuntary Admission of a Minor (§§ 16.1-341-345);*
- *Temporary Detention of an Adult or Minor (§ 37.1-67.1, § 16.1-340); and*
- *Forensic Admissions (§ 19.2-169.2, § 19.2-169.6, § 19.2-176, § 19.2-177.1, § 19.2-182.3, § 53.1-40.2, §§ 37.1-73 - 74, § 37.1-67.3 as identified in § 53.1-40.9).*

Practitioner Guidance: The legal status of individuals who are referred for forensic services is varied. Types of forensic legal status and corresponding relevant code sections are reflected in the table entitled "Legal Status of Individuals Requiring Forensic Services." (See Appendix E).

2.9 If the prescreening evaluation indicates that hospitalization is required, the clinician shall determine whether the individual is willing to be admitted voluntarily and whether the individual has the capacity to consent to voluntary hospitalization. If the individual is found to be incapable of consenting to voluntary admission, or is unwilling to be treated, and meets the Virginia criteria for involuntary admission or if the individual is fourteen years of age or older and refuses voluntary admission, then the individual may be hospitalized involuntarily, and this recommendation shall be recorded on the preadmission screening form.

When the prescreening evaluation indicates that the individual is in need of mental health care, but that hospitalization is not required, then the clinician shall begin emergency outpatient treatment or refer the individual for needed services from other community services board programs or other available providers.

The clinician shall notify the psychiatric facility where an individual will be admitted prior to the issuance of a Temporary Detention Order, an Involuntary Commitment Order or approval of a voluntary admission.

Practitioner Guidance: *Notification to the facility regarding a forthcoming admission is essential. When any state psychiatric hospital is at full occupancy, that facility will explore other arrangements with the community services board, such as a private hospital admission.*

Practitioner Guidance: *In accordance with §37.1-71 of the Code of Virginia, the judge will review transportation alternatives after commitment and may consult with treating staff and the community services board as to whether transportation alternatives may be utilized. Transportation alternatives, as specified in §37.1-72, may include placing the individual who has been certified for admission in the custody of a responsible person or persons, including a representative of the temporary detention facility in which the individual has been hospitalized.*

Practitioner Guidance: *The clinician should provide individual treatment recommendations and goals to be accomplished during the inpatient stay to the receiving hospital. This information will help the facility develop collaborative treatment planning that includes the individual, the CSB, and the hospital.*

Practitioner Guidance: *In accordance with the Attorney General Opinion relative to the transportation of persons under ECO's and TDO's, neither sheriffs' offices nor police departments have primary responsibility to transport persons subject to an emergency custody order or temporary detention order. Rather any law enforcement officer who is requested by the court to execute an ECO or TDO should do so without delay. A sheriff's office or a police department may not limit its execution of these orders to certain times of day. The Code of Virginia also provides that, should a sheriff be ordered to provide transportation of a person who has been committed to a hospital, transportation must commence within six hours of notification to the sheriff of the certification for admission. (See Appendix L).*

2.12 During the preadmission screening process, hospital personnel shall inquire about, and CSB staff are expected to provide, medical information when an individual is being considered for admission. The state psychiatric facility Medical Director or physician designee shall review with CSB prescreening staff the medical/surgical status of any individual being considered for admission when there is evidence of a medical problem. (See Appendix J).

The clinician shall attempt to contact the parents, family, or guardian of the individual who is being hospitalized and who has given consent for such contact to let them know how to participate in the individual's treatment. In cases involving minors, the clinician shall contact the parents/guardian to let them know how to participate in the individual's treatment.

Upon admission, the state psychiatric facility shall confirm and designate the "Case Management CSB" to initiate ongoing treatment coordination with that CSB.

Practitioner Guidance: *The designated "Case Management CSB" will be entered into the Patient Resident Automated Information System (PRAIS) upon the individual's admission to track and report inpatient treatment and utilization data. When confirming the "Case Management CSB" designation, the hospital may learn that the individual is a resident of a different community services board catchment area than the one in which the prescreening was done. In this circumstance, the hospital shall immediately contact both CSBs to ensure that the individual is assigned a case coordinator from the CSB serving the area where the individual resides, advise both CSBs of the "Case Management CSB" designation in the PRAIS system, and confirm the identity of the agreed upon "Case Management CSB." Specific definitions, procedures, and interpretive guidelines for the "Case Management CSB" designation can be found in "CASE MANAGEMENT CSB and Related PRAIS Data Elements," June 2, 1994. (See Appendix F).*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI coordinators in all CSBs and the Forensic Coordinators in all facilities have copies of the NGRI Manual.*

Upon admission, the state psychiatric facility shall determine whether an adult individual has executed an advance directive (formerly referred to as a living will) regarding medical treatment and health care decisions and adhere to conditions set forth in such directive, if one exists. (See Appendix I).

The state psychiatric facility shall appropriately evaluate any individual who presents at the facility for admission, whether or not they have been prescreened by a community services board. Should the hospital find that the individual does not require hospitalization, the hospital shall notify the appropriate community services board and the individual's parents if the individual is a minor child or adolescent to arrange for other services. It is the CSB's responsibility to put into place alternative services for the willing individual, if needed.

Practitioner Guidance: *In the rare instance when an individual who presents for admission has not been prescreened by a CSB, the absence of such prescreening should not delay or prevent the evaluation by the state psychiatric facility staff. State psychiatric facility staff should explore how the CSB was bypassed to avoid any such future circumstance.*

A community services board's staff member should attend all commitment hearings for residents of its catchment area, including recommitment hearings, or arrange for a surrogate or other representative to attend, regardless of the site of the commitment hearing. Surrogates can include qualified state facility or local community services board staff.

Practitioner Guidance: *Section 37.1-67.3 of the Code of Virginia makes no distinction between initial commitment and recommitment and requires a prescreening of every case*

by the CSB serving the catchment area in which the individual resides. Geographic considerations may make it impossible for a distant CSB to prescreen one of its residents in a state psychiatric facility. Under such circumstances, it is acceptable for a surrogate, such as a hospital staff or a local CSB, to conduct the evaluation on behalf of the "Case Management CSB". When such an alternative is used, the prescreening staff must review their findings and recommendations with the "Case Management CSB" prior to the commitment hearing, and any report that is presented at the hearing by an alternate prescreener must be approved by the "Case Management CSB".

When an individual requires a hearing for recommitment, staff at the state psychiatric facility shall notify the community services board at least 14 calendar days in advance of the hearing date. Community services board staff shall complete the prescreening evaluation for recommitment and attend the hearing unless other arrangements have been made with the hospital. (See 2.17).

Community services boards shall negotiate written agreements with all Juvenile and Domestic Relations and General District courts serving their catchment areas. The agreements shall specify the responsibilities of each party and the procedures to be followed in managing cases brought before the court that involve civil and forensic mental health evaluations and treatment. (See §37.1-197 in Appendix A)

Each community services board shall provide the courts and magistrates within its geographic catchment area lists of CSB employees and other designated clinicians who can perform the mental health examinations described above and in the cited statutes.

Practitioner Guidance: *A Directory of Mental Health Professionals With Training in Forensic Evaluation is available from the Department's Office of Forensic Services or the Institute of Law, Psychiatry, and Public Policy. For information, contact the Forensic Services Section in the Office of Mental Health and Substance Abuse Services, DMHMRSAS, P.O. Box 1797, Richmond, Virginia 23218 at telephone number (804) 786-4837 or Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901 at telephone number (804) 924-5435.*

3. COORDINATION OF TREATMENT PLANNING

Introduction

Treatment planning assures that an individual is thoroughly and comprehensively assessed and provided with care that is appropriate to the individual's specific treatment and support needs.

Procedures

3.1 Community services boards shall ensure that each individual hospitalized in a state psychiatric facility who will require services and supports upon return to the community is assigned a CSB case manager who will be responsible for hospital liaison activity involving the individual's treatment and discharge planning. For individuals who were homeless or transient prior to admission, a case manager from the community services board that conducted the preadmission screening shall be the liaison. The CSB case manager shall be identified on the DMHMRSAS Preadmission Screening Form (DMH 224).

Practitioner Guidance: *Individuals referred for hospitalization through the Virginia Department of Corrections or minors who are admitted from Department of Juvenile Justice (formerly the Department of Youth and Family Services) facilities and who will be returning to those facilities at discharge are not required to have a CSB case manager.*

Practitioner Guidance: *Individuals who are mentally retarded and mentally ill will be assigned a CSB case manager in accordance with established procedures reflected in the Regional Crisis Stabilization Protocol. (See Appendix K).*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI Coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of the NGRI Manual.*

3.2 The preliminary treatment plan shall be developed in accordance with the applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Health Care Finance Administration (HCFA) standards and shall be based on the information obtained through the preadmission screening process, the initial hospital assessments, and other available records.

3.3 The treatment plan shall be developed collaboratively by the hospital treatment team; the individual; the individual's parents, family, or guardian, as appropriate; the assigned community services board case manager; and other collateral agencies as appropriate. Collateral agencies may include the Department of Social Services (DSS), the Department of Health, or the Department of Rehabilitation Services (DRS).

Practitioner Guidance: When a minor aged 14 years or older objects to further voluntary treatment, the hospital will take necessary safeguards to assure the release of the minor to the consenting parent or guardian or will initiate the commitment process.

Practitioner Guidance: Hospital staff, in cooperation with community services board staff, should provide active support to the individual by informing the individual's family, parents, or guardian of treatment and discharge planning meetings and by involving the family, parents, or guardian in treatment, as appropriate, while the individual is hospitalized

Practitioner Guidance: The state psychiatric facility should notify the CSB of a projected discharge date as early in the hospital stay as possible, preferably within three days of admission and no later than two weeks after admission.

3.4 The individual shall participate fully in the development and continued refinement of the treatment plan.

Practitioner Guidance: All individuals, including persons who are hospitalized, have the right to participate in decisions that affect them. Participation in the treatment planning process is perhaps the most significant way to involve hospitalized persons in these decisions. The treatment team should work closely with the individual who is hospitalized to explore, understand, and utilize the individual's own treatment goals, expectations, and preferences about the various options available for treatment and support. There should also be opportunities to learn about and utilize the person's past treatment experiences in designing the current treatment plan. Full participation means working collaboratively with the treatment team on all aspects of treatment and support and having the opportunity to make choices about one's own treatment. This type of participation and collaboration should be integrated into the treatment planning process for all individuals who are hospitalized.

3.5 The treatment plan shall be evaluated and revised when clinical or other significant changes occur.

3.6 State facility staff shall communicate with community services board staff, family, parents, or guardian, and collateral agencies throughout the course of an individual's treatment regarding treatment strategies and approaches that seem to be most effective, events or issues that will affect the individual's functioning or support in the community after discharge, and any prescribed psychotropic medications that the individual is or will be receiving and how to manage them.

3.7 Facility staff shall provide immediate notification of the transfer of an individual to another treatment facility for medical procedures (e.g., special hospitalization) to the "Case Management CSB" and appropriate family members, parents, or guardian.

3.8 The transfer of an individual from one state facility to another shall not change the case coordination responsibilities of the "Case Management CSB".

Overnight placement of an individual in the community on pass or revocation of any type of community pass shall require notification and consultation by facility staff with the "Case Management CSB". Family members, parents or guardian, and significant others, as appropriate, shall be notified of such placements and revocations.

3.10 State facility staff shall immediately notify the "Case Management CSB" and, as appropriate, the individual's family, parents or guardian, and other collateral agencies of an individual's unauthorized absence from a state psychiatric facility and of actions taken to locate the individual. Community services boards shall assist in attempts to locate these individuals to the extent possible. Facility staff shall follow Chapter 28 in the Administrative Practices Manual on Reporting Critical Incidents.

Case coordination for each individual and progress in treatment shall be documented at the facility or community services board when such individual is an open or active client of the CSB. These records must include documentation of the ongoing involvement of CSB staff, family members, parents or guardians, and other collateral agencies, as appropriate, in treatment planning and service delivery.

4. COORDINATION OF DISCHARGE PLANNING

Introduction

Like preadmission screening, discharge planning ensures that community services boards and state psychiatric facilities manage the individual's transition between hospital to community in an effective manner. Discharge planning must be coordinated among CSBs, state psychiatric facilities, families, parents, guardian, and other collateral agencies, as appropriate, to assure continuity of care.

Procedures

4.1 The discharge plan shall be based on the individual's biopsychosocial needs and shall identify the services necessary to meet these needs in a community setting.

Practitioner Guidance: The array of treatment, life support, and rehabilitation services which may be needed to assist an individual to transition at an optimal level to the community should be considered, located, or created. Essential components that may be needed to provide adequate services and supports include the following: case management services; crisis response services; mental health treatment; stable housing; health and dental care; income support and entitlements; peer support; family and community support; rehabilitation services, including vocational and prevocational services; client identification and outreach; and protection and advocacy.

4.2 Discharge planning is the joint responsibility of the "Case Management CSB" and the state psychiatric facility.

4.3 Discharge planning for out-of-state residents, including minors who will be discharged to an out-of-state placement, is also the joint responsibility of the state facility treatment team and the "Case Management CSB".

4.4 Discharge planning for individuals who have entered Virginia state psychiatric facilities through the Interstate Transfer process is the joint responsibility of the community services board that is designated as the "Case Management CSB" at the time of admission and the state psychiatric facility.

4.5 When an individual chooses not to return to his or her home community after hospitalization, or if returning to the home community is not appropriate or possible, the discharge plan shall be jointly developed by the "Case Management CSB", the state psychiatric facility treatment team, the family, parents or guardian, and other collateral agencies, as appropriate, and with the CSB serving the community in which the individual will reside following hospitalization.

Practitioner Guidance: When returning to the home community is not appropriate or possible and when there is a lack of consensus regarding placement between the involved

CSBs' discharge planning team members, the following dispute resolution process is recommended:

If team members are unable to agree on a plan, then they should appeal to their respective supervisors within three (3) days of the initial discharge planning meeting or the initial discharge plan contact.

(B) The supervisors or the mental health/mental retardation/substance abuse directors of the involved CSBs should attempt to resolve the disagreement. If they are unable to do so, the disagreement should be referred to the heads of the agencies that employ the disagreeing parties.

There should be resolution of the disagreement within ten (10) days of the initial appeal.

4.6 The individual who is hospitalized shall participate fully in the development of his or her discharge plan. In addition, participation shall be solicited from all persons and agencies who are involved with the individual. State psychiatric facility and community services board staff shall work together to ensure that family, parents or guardian, and other collateral agencies are appropriately involved in the discharge planning process.

Practitioner Guidance: *The development of a discharge plan requires ongoing communication and negotiation among the state psychiatric facility, the community services board, and the individual, and the individual's family, parents or guardian, and other collateral agencies, as appropriate.*

Practitioner Guidance: *Prior to discharge, the individual, the CSB case manager, state psychiatric facility staff and the individual's family, parents or guardian, and other collateral agencies as appropriate should develop an assertive outreach and back-up plan to further ensure successful community re-integration.*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the discharge planning for individuals who have been found to be NGRI. The NGRI Coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of The NGRI Manual.*

4.7 The discharge plan shall be recorded in its entirety on the Discharge Plan and Referral Summary form (DMH 226). Copies of the discharge plan will be provided to the individual, family, parents or guardian of a hospitalized minor, the "Case Management CSB", and the state psychiatric facility.

4.8 Prior to discharge, the individual, and, as appropriate, his or her family, parents, or guardian, shall meet with the CSB case manager and, as appropriate, visit the community treatment, rehabilitation, support, and residential programs that are included in the discharge plan.

Practitioner Guidance: *The individual, family, parents or guardian, and other members of the individual's support system should be given the name, address, and telephone number of CSB staff who can be contacted for assistance in the event of an emergency.*

Practitioner Guidance: *Consultation and communication between the state psychiatric facility physician and the community services board physician should occur before any discharge involving unusual medical issues, including monitoring the use of drugs such as Clozapine or Risperidone.*

Practitioner Guidance: *In accordance with § 37.1-98.2, community services boards and state facilities may exchange the information required to prepare and implement a comprehensive individualized treatment and discharge plan when the individual has refused consent.*

Practitioner Guidance: *Individuals who will continue to receive services from a community services board after discharge should receive a face-to-face appointment with the CSB case manager or other service providers within one week of the date of discharge from the state psychiatric facility. An appointment with the community services board physician should be scheduled no later than two weeks after discharge.*

4.9 Discharge to an emergency shelter or similar temporary setting shall not be part of the discharge plan unless the individual's continued hospital stay is clinically contraindicated, a continued hospital stay is detrimental to the individual's course of recovery, and both of these conditions are clearly documented on the discharge plan. Such discharges must be accompanied with comprehensive community supports including a plan to secure long-term, stable housing. CSB staff must provide face-to-face follow-up of individuals discharged to emergency shelters or similar temporary settings within seven calendar days of discharge from the state psychiatric facility.

Practitioner Guidance: *The US Department of Housing and Urban Development (HUD) has specific criteria which define various conditions of homelessness and eligibility for HUD funded homeless services. Providers of these services may request documentation about homeless persons being discharged from state facilities which outlines the following: (a) that the facility's policies allow discharge to an emergency shelter for the homeless, (b) that the facility does not serve as a support network to help the person obtain housing or, which describes what steps were taken to obtain housing and certifies that no subsequent residence could be located, and (c) that the person lacks the resources and support to obtain housing independently.*

4.10 When a hospitalized individual leaves the state psychiatric facility Against Medical Advice (AMA), facility staff shall immediately notify the "Case Management CSB" and, in the likelihood that the individual will remain in the area close to the state psychiatric facility, the CSB serving the catchment area in which the facility is located. When a minor is involved in such circumstances, the individual's parent or guardian must also be notified.

4.11 Community services boards and state psychiatric facilities shall jointly review the effectiveness of their discharge planning processes and outcomes on a regular basis and at least annually. These evaluations shall be used to refine CSB and state psychiatric facility procedures, agreements, and planning and problem-solving activities.

5. POST-HOSPITAL FOLLOW-UP CARE

Introduction

Post-hospital follow-up is essential for ensuring that individuals who are discharged from state psychiatric facilities receive the necessary community services and supports to live successfully in the community. There must be continuity of care among community services and supports as well.

Procedures

5.1 The community services board shall ensure that the individual is offered post-hospital services and supports and, if such services and supports are accepted, the CSB shall monitor implementation of the discharge plan.

5.2 For individuals for whom the CSB will be the post-hospital services provider, that community services board's staff shall conduct a face-to-face interview with the individual, and as appropriate, the individual's family, parents, or guardian no later than one week after the date of discharge. If the individual fails to keep the appointment and does not reschedule, then telephone contact and assertive outreach, which may include a home visit, shall be made to assess the individual's situation and implement a revised community support plan.

5.3 Post-hospital follow-up shall be provided by the community services board serving the community in which the individual lives or, in the case of a minor, the CSB serving the community in which the minor's parent or guardian resides. In those cases where a minor has been placed at a prohibitive distance from his or her guardian, the community services board serving the catchment in which the individual is placed shall provide the post hospital follow-up, as appropriate.

Practitioner Guidance: *There are some situations in which CSBs would not be expected to continue to provide services to individuals after hospitalization. These situations arise when individuals no longer wish to receive services, when services have been successful and no further interventions are required, when an individual (or a minor's parents or guardian) cannot be engaged in services after documented efforts to re-engage them, or when all services are provided through other non-CSB affiliated agencies.*

Practitioner Guidance: *For individuals 65 years and older who are discharged from state psychiatric facilities, it may be appropriate to arrange for more intensive follow-up care. In such cases, the CSB should collaborate with state psychiatric facility staff to arrange:*

- *Face-to-face contact in the placement setting after discharge until a satisfactory adjustment has been achieved, based upon the clinical judgment of the treating staff; or*

- *Telephone contact following discharge until a satisfactory adjustment has been achieved, based upon the clinical judgment of the treating staff.*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of The NGRI Manual.*

Practitioner Guidance: *The continued involvement of and collaboration between the community services board's mental retardation and mental health program staff is essential to the successful community integration of persons who are mentally retarded and mentally ill.*

APPENDICES

Appendix A

Selected References
Statutes of Virginia Relating to the Department of Mental Health, Mental Retardation and Substance Abuse Services

Appendix B

42 CFR Confidentiality of Alcohol and Drug Abuse Records: Final Rule

Appendix C

Procedures for the Transfer of Patients to DMHMRSAS Psychiatric Facilities: Departmental Instruction No. 6

Appendix D

Psychiatric Inpatient Treatment of Minors Act: Section by Section Analysis

Appendix E

Table: Legal Status of Individuals Requiring Forensic Treatment
Selected References: Statutes of Virginia Related to the Department of Mental Health, Mental Retardation and Substance Abuse Services (Forensic)

Appendix F

"Case Management CSB" and Related PRAIS Data Elements

Appendix G

Philosophy/Values of System of Care: Principles of Service Delivery; (Mental Health Plan, 1996)

Appendix H

Forms Related to Continuity of Care

Appendix I

Patient Self Determination Act:
Departmental Instruction No. 120

Appendix J

Medical Screening:
Departmental Instruction No. 131

Appendix K

Regional Crisis Stabilization Protocol

Appendix L

Attorney General Opinion on Transportation Under ECO's and TDO's

Appendix M

State Board Policy 1029, June 1990 - Definition of Serious Mental Illness